IMPORTANT...

Admission & Application Information:

Contact Information:

(Application Info./Admissions):
Debbie Slemp
Director of Social Services
Admissions Coordinator
Phone:(859) 858-2814
Fax #: (859) 858-4039

(Financial Questions):
Ruth Lynch
Financial Officer
Phone: (859) 858-2814
Fax #: (859) 858-4039

***If you have any questions about your application, or the admission process, please contact Debbie Slemp.**

***If you have financial questions, call Ruth Lynch.**

***We are in the office Monday thru Friday, but our actual working hours may vary from day to day. Please call ahead and make an appointment before coming to the facility. We do not want you to make a long drive only to find out we are not in and/or do not have an appointment time open. Otherwise, leave us a voice mail and we will get back with you as soon as possible. Please remember to speak slowly, clearly, and to spell anything we may have trouble understanding on the answering machine.**

Thank you.

Debbie Slemp

STEVE BESHEAR
GOVERNOR

DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF KENTUCKY VETERAN CENTERS
THOMSON-HOOD VETERANS CENTER

100 VETERANS DRIVE
WILMORE, KENTUCKY 40390
(859) 858-2814
www.thvc.ky.gov

KENNETH R. LUCAS
COMMISSIONER

GILDA HILL
ADMINISTRATOR

TO: Residents, Families and Responsible Parties

FROM: Gilda Hill, RN, BSN, LNHA
Administrator

DATE: September 23, 2008

SUBJECT: Washing of Clothing

The Laundry Department at Thomson-Hood Veterans Center will strive to maintain clean clothing for you while you are a resident in this facility.

However, we are required to wash clothing in a high water temperature. Hot water causes damage to various type of materials such as wool and silky type cloth. Please do not bring in articles of clothing made from material that cannot be washed in high temperatures.

We do not provide dry cleaning services. Any clothing that needs to be dry cleaned is the responsibility of the resident.

THVC cannot be responsible for clothing that is damaged by washing.

If you have any questions concerning laundering of clothing, please contact Courtney, Laundry Supervisor at 859-858-2814 ext 233.

Commonwealth of Kentucky
DEPARTMENT OF VETERANS' AFFAIRS
Office of Kentucky Veterans' Centers
1111 Louisville Road
Frankfort, Kentucky 40601
(502) 564-9281
(888) 724-7683

Dear Potential Resident/Family Member:

Thank you for your interest in the Kentucky Veterans Centers. We realize that the decision to place a loved one into a long-term care facility is not an easy one, and our goal is to make the transition as effortless and pleasant as possible.

At the top of the enclosed application you will find the names of the three state veterans nursing homes we operate. Please check the box beside the home or homes in which you are interested in applying for admission.

There are admission coordinators at each home who are trained to assist, guide, and direct you through the application process. The address and telephone numbers of the admission coordinators are listed below, and we encourage you to contact them for any assistance needed.

In order to expedite the process, we have attached a list of items that are needed to help determine your eligibility, level of care, and financial responsibility. Please forward these items to us along with your completed application. Again, if any assistance is needed, please do not hesitate to contact one of the below facilities.

Thomson-Hood Veterans Center	Eastern Kentucky Veterans Center	Western Kentucky Veterans Center
ATTN: Admissions Coordinator	ATTN: Admissions Coordinator	ATTN: Admissions Coordinator
100 Veterans Drive	200 Veterans Drive	926 Veterans Drive
Wilmore, Kentucky 40390	Hazard, Kentucky 41701	Hanson, Kentucky 42413
(859) 858-2814	(606) 435-6196	(270) 322-9087
(800) 928-4838	(877) 856-0004	(877) 662-0008
Fax (859) 858-4039	Fax (606) 435-6201	Fax (270) 322-9497
TTYS (859) 858-4226		

We appreciate your service to the nation and extend our gratitude for the opportunity to serve you, the veterans of America's Armed Forces!

Sincerely,

David G Worley

David Worley
Executive Director
Office of Kentucky Veterans' Centers

*Please direct any "Financial" questions to Ruth Lynch; ext. 251.

Keep for your records

☐ Thomson-Hood Veterans Center
100 Veterans Drive
Wilmore, KY 40390

☐ Eastern Kentucky Veterans Center
200 Veterans Drive
Hazard, KY 41701

☐ Western Kentucky Veterans Center
926 Veterans Drive
Hanson, KY 42413

Please place a check in the box next to the home you are interested in.

No individual will, on the grounds of race, color, handicap, HIV status or national origin, be denied admission, care or any other benefit provided by the Kentucky Veterans Centers.

INSTRUCTIONS:

1. Applications must be TYPEWRITTEN or PRINTED IN INK.

2. Veterans must have anything other than a dishonorable discharge and meet those criteria required by the United States Department of Veterans Affairs for veteran's status.

3. Applicant must be a resident of Kentucky.

COUNTY OF RESIDENCE: **Where is the veteran currently living/receiving care?**	**DATE:**

In compliance with the eligibility requirements, I do hereby apply for admission to the Kentucky Veterans long term care facility checked above, and declare the following statements and information to be true:

NAME	**SOCIAL SECURITY NUMBER**
ADDRESS (STREET OR RFD)	**TELEPHONE NUMBER**
CITY, COUNTY, ZIP CODE	

DATE OF BIRTH	**SEX**	**AGE**
PLACE OF BIRTH		**RELIGION**

MARTIAL STATUS ☐ SINGLE ☐ MARRIED ☐ DIVORCED (PLEASE PROVIDE COPY OF DIVORCE)
☐ WIDOWED (PLEASE PROVIDE COPY OF DEATH CERTIFICATE OF SPOUSE)
☐ LEGAL SEPARATION (PLEASE PROVIDE COPY OF DECREE)

NAME OF SPOUSE (maiden name)	**SPOUSE'S SOCIAL SECURITY NUMBER**
SPOUSE'S ADDRESS	**SPOUSE'S DATE OF BIRTH**

DATE AND PLACE OF MARRIAGE (PLEASE PROVIDE COPY OF MARRIAGE LICENSE)

MILITARY SERVICE INFORMATION (Please provide copy of DD 214/Discharge)

BRANCH AND SERVICE NUMBER	**DATE AND PLACE OF ENLISTMENT**	**DATE AND PLACE OF DISCHARGE**	**TYPE Of DISCHARGE**

IF YOU HAVE EVER BEEN A RESIDENT OF THE KENTUCKY VETERANS CENTER OR OTHER STATE OR FEDERAL LONG TERM CARE FACILITY, PLEASE COMPLETE THE FOLLOWING:

DATE OF DISCHARGE	**FACILITY**	**REASON**

HAVE YOU BEEN A PATIENT IN A HOSPITAL WITHIN THE LAST SIX MONTHS? ☐ Yes ☐ No
If Yes, please complete the following:

Name of Hospital/Private Physician	**Address of Hospital/Physician**
Name of Hospital/Private Physician	**Address of Hospital/Physician**

DO YOU HAVE MEDICARE? ☐ YES ☐ NO PART A_____PART B_____EFFECTIVE DATES:_____ MEDICARE NUMBER _____(Provide copy)	DOES YOUR SPOUSE HAVE MEDICARE? ☐ YES ☐ NO MEDICARE NUMBER_____(Provide copy)
DO YOU HAVE ANY OTHER HEALTH/MEDICAL INSURANCE: ☐ Yes ☐ No COMPANY AND NUMBER_ _____ (Provide copy & verification of premium due)	DOES YOUR SPOUSE HAVE ANY OTHER HEALTH/MEDICAL INSURANCE ☐ YES ☐ NO COMPANY AND NUMBER_____ (Provide copy & verification of premium due)

INCOME AND ASSETS

YOU HAVE TWO OPTIONS FOR PAYMENT; IF YOU CHOOSE NOT TO DISCLOSE YOUR ASSETS, PLEASE READ THE FOLLOWING STATEMENT AND SIGN:

I DO NOT WISH TO PROVIDE MY DETAILED FINANCIAL INFORMATION. I UNDERSTAND THAT I WILL BE ASSESSED THE MAXIMUM AMOUNT FOR EXTENDED CARE SERVICES AND AGREE TO PAY THE MAXIMUM CHARGE.

SIGNATURE **DATE**

YOUR SECOND OPTION IS TO DISCLOSE YOUR ASSETS AND YOU WILL BE CHARGED BASED ON YOUR ABILITY TO PAY. IF YOU ELECT THIS OPTION, PLEASE PROVIDE THE INFORMATION REQUESTED BELOW:

LIST ALL REAL ESTATE YOU AND/OR YOUR SPOUSE OWN OR IN WHICH YOU AND/OR YOUR SPOUSE HAVE ANY INTEREST. (Give location, size, description and approximate value. State whether held solely or jointly with husband/wife).

LIST ALL SECURITIES WHICH YOU AND/OR YOUR SPOUSE OWN. (Include cash on hand or in safety deposit box, savings, checking accounts, time deposits, stocks, bonds, postal savings, notes, mortgages, or any other money or securities. Give amount and where located). (Provide verification of all securities listed).

LIST THE PERSONAL PROPERTY WHICH YOU AND/OR YOUR SPOUSE OWN. (Include auto, truck, livestock, furniture, farm equipment, business inventory, etc. Give approximate value and where located).

LIST ANY INDEBTEDNESS OTHER THAN THAT SECURED BY YOUR PRIMARY RESIDENCE. (Include amounts, payee, due dates and reason for indebtedness).

LIST ANY INSURANCE POLICES WHICH YOU AND/OR YOUR SPOUSE HAVE. (Include burial, life, hospital, health and accident. Give name of company and face and/or current cash value). (Provide copies).

LIST GROSS AMOUNTS OF MONTHLY INCOME:	VETERAN	SPOUSE
Wages	$	$
VA Pension	$	$
VA Compensation: Percent of Compensation _____	$	$
Social Security	$	$
Medicare	$	$
Retirement Income	$	$
Pension Income	$	$
Other Retirement Income	$	$
Interest	$	$
Dividends	$	$
Income from rental properties	$	$
Court Mandated(Alimony, Child Support)	$	$
Other Income	$	$
Other Income	$	$

PERSONS TO BE NOTIFIED IN AN EMERGENCY. (List two. If applicant has a guardian, conservator, or power of attorney, copies of the legal documents establishing such authority must be attached).	
NAME	RELATIONSHIP
ADDRESS	WORK PHONE
CITY, STATE, ZIP CODE	HOME PHONE
NAME	RELATIONSHIP
ADDRESS	WORK PHONE
CITY, STATE, ZIP CODE	HOME PHONE

BURIAL ARRANGEMENTS

Name of Undertaker to be called
Address of Undertaker
Desired Location of Burial
Name of person taking care of arrangements, if any

CERTIFICATION

I_____, do solemnly affirm that I fully understand requirements that must be met, and all qualifications that must be possessed by an applicant for admission to the facility. I fully understand all questions asked on this application and that all statements made by me on this application are true. I am a resident of the Commonwealth of Kentucky and affirm that because of physical disability, I am unable to continue living in my home. I further agree to accept transfer to any other health care facility, or to my home, if in the opinion of the staff such transfer is necessary. This application is my free and voluntary act.

I also certify that I have provided all requested information regarding my assets, indebtedness and income (including that related to my spouse) and that such information is complete and correct. I also agree to provide required proof of all income, assets, and indebtedness upon request. I understand that my admission and continued stay in the Kentucky Veterans Center is subject to a true and accurate reporting of my financial status. Misrepresentation of my financial status may result in my immediate discharge from the Kentucky Veterans Center.

I also understand that the professional staff at the facility shall have the right to deny admission if, in their opinion, my needs cannot be adequately met at the facility.

I hereby authorize the Kentucky Veterans Center to apply for any financial benefits to which I may be entitled.

I understand that a non-medical leave of absence from the facility in excess of 96 hours (4 days) will result in a charge per day equal to the current VA Per Diem rate in effect at the time. This charge will be retroactive to the first day of absence from the facility and will cover the entire period of absence.

I understand the monthly charges by the facility and agree to pay in full any charges within ten days of receipt.

Signature of Applicant **Date:**
(or Legal Representative)

Application Checklist includes but is not limited to the following:

- **Medical records from all healthcare providers seen in the six months prior to application and extending to date of admission.**
- **Proof of Kentucky residency.**
- **Proof of all income amounts listed herein.**
- **Documentation of all real estate listed other than the primary residence to include copy of deed, property tax assessment, and/or mortgage.**
- **Statements of account for all securities (cash on hand or in safety deposit box, savings, checking accounts, time deposits, stocks, bonds, postal savings, notes, mortgages, or any other money) listed herein for the three months prior to application and extending to date of admission.**
- **Documentation of all personal property listed herein other than one primary automobile.**
- **Copies of all insurance policies listed.**
- **Copies of medicare and health insurance cards (front and back).**
- **If applicable, copy of monthly premium paid on supplemental health insurance.**
- **Tax return for previous year, if applicable.**
- **Copies of all outstanding debts listed.**
- **Alimony/child support documentation.**

ADDITIONAL COMMENTS

Completion of this section is voluntary

A. ☐ American Indian or Alaskan Native

B. ☐ Asian or Pacific Islander

C. ☐ Black (Not of Hispanic origin)

D. ☐ Hispanic

E. ☐ White (Not of Hispanic origin)

Information is used only for statistical purposes

APPLICATION FOR ADMISSION CHECKLIST:

MEDICAL & LEGAL INFORMATION REQUIRED TO PROCESS YOUR APPLICATION: (ALL items listed must be provided in order for the application to be processed and considered for admission).

- ☐ **A copy of the power of attorney/guardianship papers.**
- ☐ **A copy of the residents living will/advance directives.**
- ☐ **A copy of discharge from military service, (DD214), or other military document showing dates of service.**
- ☐ **A copy of military ID, if military retiree.**
- ☐ **A copy of social security card.**
- ☐ **Verification of Kentucky residency, (mail items showing current address, utility bills, driver's license, etc.).**
- ☐ **Copies of all insurance cards, (front & back), ie. Medicare, Medicaid, and private insurance.**
- ☐ **Current history & physical, (within past 30 days).**
- ☐ **Current medication/treatment list, including herbal and over the counter meds.**
- ☐ **Current PPD skin test status or proof of negative chest X-ray if PPD positive.**
- ☐ **Current Height and Weight.**

***If the applicant is currently in a nursing facility, please provide: (items listed below plus the items listed above).**

- ☐ **Nursing monthly summaries for previous 3 months.**
- ☐ **Nursing notes for previous 3 months.**
- ☐ **MDS Assessment, and Care Plan.**
- ☐ **Social Work notes.**
- ☐ **Diet information.**
- ☐ **Current medication list.**
- ☐ **Immunization records.**
- ☐ **Skin assessment.**
- ☐ **Recent lab reports.**

***If the applicant is not currently in a nursing facility, please provide: (items listed below plus the ones listed at top of page).**

- ☐ **Discharge summary from recent or current hospital stay. Hospital nursing notes, lab results, x-ray reports, social worker notes, psychiatric notes, diet information, etc.**

*You may sign a Release of Information form at the MD office, nursing home, hospital, etc. and have them fax the medical record information directly to the Admission Coordinator.

FINANCIAL INFORMATION REQUIRED FOR ADMISSION:

☐ Verification of ALL Gross income amounts you/or your spouse receive per month.

$_____ Income from previous year (pensions, social security, interest, dividends, retirement).

$_____ Total out of pocket medical expenses for prior year (Medicare premium, health insurance premium, co-pay for office visits, medications, eye glasses, hearing aids).

☐ Please provide copies of check & check stubs you receive for any income that are not direct deposited. Income amounts must verify gross amount before withholdings.

☐ Copies of the tax return for the previous year, if applicable.

☐ Copy of the monthly premium paid on supplemental health insurance for you/or your spouse, if applicable.

☐ Three (3) months of bank statements for checking and savings account starting with the most current statement.

Copies of the following that are applicable:

- ☐ Market value of any property other than your primary residence.
- ☐ Market value of additional vehicles other than your primary vehicle.
- ☐ Certificates of Deposit (current value with current interest rate), IRA's, Stocks, Bonds, Money Market Accounts, Life Insurance Policies (cash value) and Burial Funds.

☐ Copies of outstanding debts i.e. medical bills, credit cards.

☐ A copy of your current marriage license. If widowed, divorced or legally separated, provide documentation of this fact also property settlement if applicable. If paying child support or alimony, please provide court documents.

☐ Letter from current nursing or most recent nursing home to verify financial obligation is being or has been met.

If you have any questions regarding the admissions or financial process, please contact the homes' admissions coordinator or financial officer at your convenience.

OMB Number: 2900-0260
Estimated Burden: 2 minutes

Department of Veterans Affairs

Privacy Act and Paperwork Reduction Act Information: The execution of this form does not authorize the release of information other than that specifically described below. The information requested on this form is solicited under Title 38, U.S.C. The form authorizes release of information in accordance with the Health Insurance Portability and Accountability Act, 45 CFR Parts 160 and 164, 5 U.S.C. 552a, and 38 U.S.C. 5701 and 7332 that you specify. Your disclosure of the information requested on this form is voluntary. However, if the information including Social Security Number (SSN) (the SSN will be used to locate records for release) is not furnished completely and accurately, Department of Veterans Affairs will be unable to comply with the request. The Veterans Health Administration may not condition treatment, payment, enrollment or eligibility on signing the authorization. VA may disclose the information that you put on the form as permitted by law. VA may make a "routine use" disclosure of the information as outlined in the Privacy Act systems of records notices identified as 24VA19 "Patient Medical Record - VA" and in accordance with the VHA Notice of Privacy Practices. You do not have to provide the information to VA, but if you don't, VA will be unable to process your request and serve your medical needs. Failure to furnish the information will not have any affect on any other benefits to which you may be entitled. If you provide VA your Social Security Number, VA will use it to administer your VA benefits. VA may also use this information to identify veterans and persons claiming or receiving VA benefits and their records, and for other purposes authorized or required by law. The Paperwork Reduction Act of 1995 requires us to notify you that this information collection is in accordance with the clearance requirements of section 3507 of the Paperwork Reduction Act of 1995. We may not conduct or sponsor, and you are not required to respond to, a collection of information unless it displays a valid OMB number. We anticipate that the time expended by all individuals who must complete this form will average 2 minutes. This includes the time it will take to read instructions, gather the necessary facts and fill out the form.

Thomson-Hood Veterans Center, 100 Veterans Drive, Wilmore, KY 40390
Attn: Debbie Slemp Fax: (859)858-4039

VETERAN'S REQUEST: I request and authorize Department of Veterans Affairs to release the information specified below to the organization, or individual named on this request. I understand that the information to be released includes information regarding the following condition(s):

INFORMATION REQUESTED (Check applicable box(es) and state the extent or nature of the information to be disclosed, giving the dates or approximate dates covered by each)

NOTE: ADDITIONAL ITEMS OF INFORMATION DESIRED MAY BE LISTED ON THE BACK OF THIS FORM

AUTHORIZATION: I certify that this request has been made freely, voluntarily and without coercion and that the information given above is accurate and complete to the best of my knowledge. I understand that I will receive a copy of this form after I sign it. I may revoke this authorization, in writing, at any time except to the extent that action has already been taken to comply with it. Written revocation is effective upon receipt by the Release of Information Unit at the facility housing the records. Redisclosure of my medical records by those receiving the above authorized information may be accomplished without my further written authorization and may no longer be protected. Without my express revocation, the authorization will automatically expire: (1) upon satisfaction of the need for disclosure; (2) on (date supplied by patient); (3) under the following condition(s):

I understand that the VA health care practitioner's opinions and statements are not official VA decisions regarding whether I will receive other VA benefits or, if I receive VA benefits, their amount. They may, however, be considered with other evidence when these decisions are made at a VA Regional Office that specializes in benefit decisions.

Authorization to Use or Disclose Health Information - Thomson-Hood Veterans Ctr.

I, _____, (Date of Birth_____) authorize Thomson-Hood Veterans Center to use or disclose a copy of my health information as identified below to/from _____

_____

for the following purposes:

_____

By **initialing the space(s) below**, I specifically authorize the use or disclosure of the following health information and/or medical records:

_____ Please send the entire medical record (all information) to the above-named recipient.

_____ Discharge Summary _____ History and Physical Examination

_____ Nurses Notes _____ Physician Progress Notes/Orders

_____ Laboratory Reports _____ Diagnostic Imaging Reports

_____Other:_____
_____
_____

I understand that, for certain information to be disclosed, state or federal laws and regulations require my specific authorization as follows **(please initial to verify authorized use or disclosure)**

_____ *HIV/AIDS related health information and/or records

_____ *Genetic testing information and/or records

_____ *Mental health information and/or records

_____ *Drug/alcohol diagnosis, treatment or referral information (Federal regulations require a description of how much and what kind of information is to be disclosed. **Federal law prohibits the redisclosure of such information.**)

Describe: _____
_____
_____

_____ *Psychotherapy Notes (If this authorization is for the use or disclosure of psychotherapy notes, then it cannot be combined with any other authorization.)

I understand that, if the person or entity receiving the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be redisclosed and no longer protected by these regulations. However, the recipient may be prohibited from disclosing substance abuse information under the federal substance abuse confidentiality requirements.

I also understand that the person I am authorizing to use or disclose the information may receive compensation for doing so.

I further understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits. I may inspect or copy any information to be used or disclosed under this authorization.

Finally, I understand that I may revoke this authorization at any time, provided that I do so in writing, except to the extent that action has been taken in reliance upon this authorization. Unless revoked earlier, this authorization will expire 180 days from the date of signing.

_____ _____

Signature of resident or resident's legal representative Date

_____

Print resident's name

_____ _____

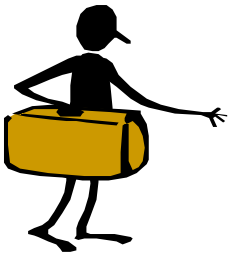
Print name of legal representative (if applicable) Relationship to resident

_____ _____

Witness Date

(A copy of this signed form will be provided to the resident.)

THVC# 124 rev. 07/98; rev. 11/03



WHAT TO BRING???

PERSONAL ARTICLES to bring for ADMISSION

Upon admission residents do not need large amounts of clothing due to our laundry facility laundering their clothing daily. We recommend only the items listed below, in order to keep closets from becoming cluttered and to avoid wrinkling of clothing.

***Thomson-Hood Veterans Center** furnishes all blankets, bedspreads, sheets and pillows; you may bring 1 extra blanket if desired.

***Thomson-Hood Veterans Center** will label all clothing items for you. We have an iron-on labeling machine that prints iron-on labels for our residents clothing. If you bring in any new/additional clothing items, (ie. birthdays, Christmas, change of season, etc.), please make sure you take them to the nurse manager or social worker to be labeled "before" you put them in their room/closet. If they get taken down to laundry in the dirty clothes and are not labeled, they have no way of knowing who to return them to.

If you bring any "non" clothing items, (such as pictures, radio, clock, etc.), you will need to label these items with a sharpie marker or ink pen prior to bringing them in. We also encourage you not to bring anything of great value. If an item is lost, please notify your nurse manager or social worker as soon as possible. We will make a diligent effort to find the lost item, and return it, but we are not responsible for lost/stolen items.

Check List for Personal Articles

Shirts/blouses	**8-10**
Pants/slacks	**8-10**
Undershirts	**10**
Underwear	**10**
Socks	**10**
Belts/Shoes	**2 ea**
Handkerchiefs	**12**
Housecoat	**1**
Pajamas/gown	**4**
Sweaters/Light	**2 ea**
Winter coat	**1**

FURNITURE and ROOM FURNISHINGS

Televisions: All rooms are equipped with a TV that is on a pivotal arm, (ie. they can move it to watch TV from their bed or their side chair) **NO other TV's may be brought in.**

Furniture: ALL rooms are furnished with a bed, chest of drawers—top drawer has a lock/key, wall shelf, side chair, and a nightstand.

No other furniture items may be brought in without "prior" approval from the administrator. All rooms have a closet space with a large drawer for each resident. We must be careful not to infringe upon other residents space in the room, and therefore can not allow the rooms to be cluttered. Clutter can also cause falls and limit adequate room for staff to provide care.

Closets: We need you to assist us in keeping the residents' closets neat and stocked with appropriate clothing. Please go through their clothing items every few months, to make sure any torn/tattered items are removed, and/or that seasonal items are exchanged out. Closet space is limited and we want our residents to look nice and be comfortable at all times. Please take home any non-seasonal items or items that no longer fit. *Please remember to give any new/additional items you bring in to the nurse manager or social worker so they can be labeled. They will take them down to laundry for labeling and put them away when they are brought back to the unit.

Electrical Devices: ALL rooms are equipped with electrical outlets.

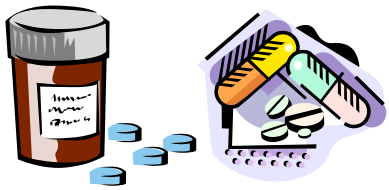
No extension cords or power-strips can be used in resident rooms. You may bring in a clock/radio but they must be in safe operating order, (ie. no frayed wires/cords, broken cases, etc.). Wireless Internet is provided for residents to use with his/her own laptop. Laptops are the only computer allowed in resident rooms due to space limitations. The Library has computers for residents to use for Internet access as well.

Food/Snacks: Residents may keep snacks in their room. However, they must be dated, kept in an air-tight container, and limited to small quantities. Close monitoring of all stored food items is important due to infection control.

No food items that require refrigeration may be kept in the room. Items requiring refrigeration need to be checked in with nursing and labeled with the residents name.

All nursing units have a kitchenette with a refrigerator for these items to be stored. We encourage residents/family to inspect their snacks frequently to make sure they do not become outdated or unfit for consumption.

Free snacks are also provided daily on the nursing units.



MEDICATIONS:

NO Outside Medications

NO outside medications may be brought in for residents.

Only medications administered by THVC are permitted. It is very dangerous for residents to consume or use outside medications. This includes all over-the-counter medicines, herbal remedies, and ointments/creams. The physicians monitor all resident medications and adjust them as needed. If any medications are found in resident rooms they will be destroyed and an investigation conducted as to where they came from. If your loved one expresses a need for additional medication, notify the nurse manager or physician for assistance.

THOMSON HOOD VETERANS CENTER

Our Amenities

Our facility offers a wide array of important services for the convenience, comfort and well being of our veterans. These amenities include:

- ◊ *Primary care physicians*
- ◊ *24 hour Nursing Care*
- ◊ *Speech Therapy*
- ◊ *Physical Therapy*
- ◊ *Occupational Therapy*
- ◊ *Pharmaceutical services*
- ◊ *Laboratory Services*
- ◊ *Library w/internet access*
- ◊ *Gift Shop*
- ◊ *Arts and crafts*
- ◊ *Activities*
- ◊ *Barber Shop*
- ◊ *Dementia/Alzheimer's care*

Kentucky's first facility opened in August 1991. The 285 bed facility is located on 30 acres of beautiful rolling farm land 15 miles south of Lexington in the city of Wilmore.

100 Veterans Drive
Wilmore, Kentucky 40390
Phone: (859) 858-2814
Toll free: (800) 928-4838
FAX: (859) 858-4039
www.thvc.ky.gov

⇒ The T□VC is licensed by the Commonwealth of □entucky, □epartment of □uman □esources, □ivision of □icensing and □egulation.

⇒ The facility is licensed for □□□nursing care beds. The license number is 1□□□□1. The license is displayed in the front lobby of the facility.

Admission Criteria

- * *Must be a veteran with other than a dishonorable discharge and a current resident of the Commonwealth of Kentucky.*
- * *Prior to admission, each application is reviewed to ensure that medical needs of the veteran can be met.*
- * *No individual shall be denied admission based on the grounds of race, color, handicap, age, gender, religion, national origin or HIV status.*

CARING FOR OUR HEROES EVERYDAY

OUR MISSION

The Thomson-Hood Veterans Center (THVC) is dedicated to promoting and maintaining a standard of excellence. Emphasis shall be placed on preservation of residents' rights and assisting the residents to maintain the highest possible level of independence. This includes respect for the residents to be treated as individuals with the right to privacy and preservation of dignity.

The THVC shall adhere to all state and federal legislation and, to the extent possible, shall strive to exceed minimum standards to ensure the health, safety, and emotional well-being of the residents. The facility staff shall work as a team to accomplish these goals.

In an effort to remain current on health care trends for the elderly, education of staff shall be emphasized. This shall be accomplished through in-service, both formal and informal, and by collaborating with other agencies for the purpose of sharing knowledge.

The services of volunteers shall be solicited and used to their fullest extent to assist the veterans in achieving their maximum potential of independence. Community involvement with the residents shall be encouraged. Ways in which the resident may contribute to the enhancement of the community shall be explored.

KY State Veterans Centers

The Commonwealth of Kentucky operates long-term care facilities for Kentucky's veterans offering a broad range of versatile nursing care. Each facility has a compassionate and professional staff committed to providing thoughtful, quality care. These facilities are also fully prepared to provide care for dementia and Alzheimer residents. Additionally, all of our homes are outfitted with state of the art equipment. Physical therapy and recreational activities are available to help our residents achieve their ultimate functioning abilities. Finally, and most importantly, we are fully dedicated to providing this long-term care service to our patriots.

Serving those who have served the Commonwealth and our great Nation

The Cost

Residents are charged a reasonable monthly fee based on the veteran's ability to pay, so everyone's situation is different.

Please contact the Admissions Coordinator for more detailed information concerning costs associated with this long-term care service.

Keep for your records

STEVE BESHEAR
GOVERNOR

DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF KENTUCKY VETERAN CENTERS
THOMSON-HOOD VETERANS CENTER

100 VETERANS DRIVE
WILMORE, KENTUCKY 40390
(859) 858-2814
www.thvc.ky.gov

KENNETH R. LUCAS
COMMISSIONER

GILDA HILL
ADMINISTRATOR

Thomson-Hood Veterans Center
Authorization to Use or Disclose Health Information Form

THVC's Authorization to Use or Disclose Health Information form is provided to you to use as needed. If it is necessary to use, you must complete ALL of the following items on both pages (HIPAA requirements):

First page, complete-
- **Name of Applicant**
- **Date of Birth**
- **To/From** whom the medical information is being requested from
- **Purpose** of this request – "Potential admission into Thomson-Hood Veterans Center"
- **Initial** items of information that are needed to be provided ***From*** them ***to*** THVC,
- **Initial** any condition(s) for which he / she has received treatment or been diagnosed

Second page,
- **SIGN your name** and **date,** or **SIGNATURE of POA** if this is the case
- **PRINT your name,** or the **applicant's name** if being completed by POA
- **PRINT name of Legal Representative / state RELATIONSHIP to Resident**
- **Witness / Date MUST** be completed

Either mail this original form to the person / organization that the medical information is needed from, or you may ask that the information be faxed as soon as possible so they can be sent in with your application for admission.

Please call me or the Medical Records Department (x236 / 323) with any questions or concerns about this form.

Thank you,

Debbie Slemp, CSW, CPM
Director, Social Services
Admissions Officer

MONTHLY RESIDENT CHARGES 3.03

The calculation of resident charges at state veterans' nursing homes will be assessed according to 17 KAR 3:010.

Example Monthly Charge - Number 1

	Resident with No Dependents	Resident with Dependents
Net Worth at Date of Admission		
Market value of stocks	$ 5,000	$ 5,000
Savings account	3,500	3,500
Individual retirement account	15,420	15,420
Real estate (other than primary residence)	22,000	22,000
Total assets	45,920	45,920
Less Resident Burial Asset Exclusion	-10,000	-10,000
Less Spouse Asset Exclusion	N/A	-35,920
Resident's Net Worth	$35,920	$ 0
Total Resources		
Interest income per month	$ 18	$ 18
Dividend income per month	21	21
VA Pension with Aid and Attendance	951	1,400
Resident's Net Worth	35,920	0
Sub Total	36,910	1,439
Less Spouse Allowance	N/A	-1,500
Less Resident's Allowance	-150	-150
Resident's Total Resources	$36,760	$ 0
KVC Monthly Charge		
Since the resident's total resources are	$36,760	$ 0
KVC's initial monthly charge is	$ 3,500	$ 0

Example Monthly Charge - Number 2

	Resident with No Dependent(s)	Resident with Dependent(s)
Net Worth at Date of Admission		
Checking account	$ 6,500	$ 6,500
Savings account	35,000	35,000
Individual retirement account	18,200	18,200
Real estate (other than primary residence)	27,000	27,000
Market value of stocks	84,000	84,000
Total assets	170,700	170,700
Less Resident Burial Asset Exclusion	-10,000	-10,000
Less Spouse Asset Exclusion	N/A	-100,000
Resident's Net Worth	$160,700	$ 60,700
Total Resources		
Interest income per month	$ 175	$ 175
Dividend income per month	280	280
Private pension per month	1,420	1,420
Resident's Net Worth	160,700	60,700
Sub Total	162,575	62,575
Less Spouse Allowance	N/A	-1,500
Less Resident's Allowance	-150	-150
Resident's Total Resources	$162,425	$ 60,925
KVC Monthly Charge		
Since the resident's Total Resources are	$162,425	$ 60,925
Which is an amount in excess of $3,500 KVC's monthly charge is	$ 3,500	$ 3,500

MONTHLY RESIDENT CHARGES 3.03

The maximum charge for room and care will be assessed according to 17 KAR 3:020.

Maximum Room and Care Charges

	Maximum Charge	
Inpatient Room	Daily*	Monthly
Skilled Care - Private	Not available	
Skilled Care - Semi-Private	Not available	
Intermediate Care - Private	Not available	
Intermediate Care - Semi-Private	Not available	
Personal Care	Not available	
Nursing Facility Beds - Private	$ 116.66	$ 3,500
Nursing Facility Beds - Semi-Private	$ 116.66	$ 3,500
Nursing Home Beds - Private	Not available	
Nursing Home Beds - Semi-Private	Not available	

* Admissions with duration of less than one month, the KVC charges $ 116.66 per day.

MONTHLY RESIDENT CHARGES **3.03**

Common Services, Procedures and Tests

Description	Maximum Fee Charges
Rehab Services:	
Physical Therapy Treatment	No additional charge [1]
Hydro Therapy - Highboard Type	Not available
Hydro Therapy - Whirlpool	No additional charge [1]
Occupational Therapy Treatment	No additional charge [1]
Speech Therapy Treatment	No additional charge [1]
Other Services:	
X-ray Services	VAMC - No THVC charge
Naso-Gastric and Gastrostomy Tube Feedings	No additional charge [1]
Wound Care Services	No additional charge [1]
Blood Glucose Level Checks	No additional charge [1]
Colostomy/Ileostomy Care	No additional charge [1]
Therapeutic Diets	No additional charge [1]
Wandering Security Device	No additional charge [1]
Gaseous Oxygen	No additional charge [3]
Pulse Oximeter Test	No additional charge [3]

[1] Noted service, procedure or test is provided by the KVC (including supplies and equipment) at no additional charge over the fee for room and board which is applicable for the period of admission.

[2] Noted service is provided by the KVC at bedside only at no additional charge over the fee for room and board which is applicable for the period of admission.

[3] Noted service or equipment is provided by the KVC under certain circumstances. When provided, such service or equipment is provided at no additional charge over the fee for room and board which is applicable for the period of admission.

Reviewed: May 15, 2000
Revised: July 1, 2000
Reviewed: March 25, 2004
Revised: April 1, 2007
Revised: January 1, 2009

Approved:

Gilda Hill

Gilda Hill, RN, BSN, LNHA
Administrator

17 KAR 3:010. Calculation of resident charges at state veterans' nursing homes.

RELATES TO: KRS 40.320, 40.325
STATUTORY AUTHORITY: KRS 40.325(2)
NECESSITY, FUNCTION, AND CONFORMITY: KRS 40.320 identifies the Commonwealth's duty to provide for the well-being of elderly and disabled veterans within state veterans' nursing homes. KRS 40.325(2) authorizes the Department of Veterans' Affairs to promulgate any administrative regulations necessary to operate the homes in compliance with applicable state and federal statutes and regulations. This administrative regulation establishes the requirements for calculating resident charges for room and care services within the state veterans' nursing homes.

Section 1. Definitions. (1) "Ability to pay" means the total amount of available assets and available monthly income on the part of the resident and spouse.

(2) "Administrator" means the person in charge of a state veterans' nursing home, or that person's specific designee.

(3) "Assets" means the market value of items owned by the resident and spouse as applicable including:

(a) Stocks, bonds, and notes;
(b) Individual retirement accounts;
(c) Bank deposits;
(d) Savings accounts;
(e) Cash;
(f) Real estate;
(g) Cash value of life insurance policies; or
(h) Face value of prepaid burial plans.

(4) "Available assets" means the total assets of the resident and spouse less the applicable exclusions specified in Section 2(5) of this administrative regulation.

(5) "Available monthly income" means the gross monthly income of the resident and spouse less the applicable exclusions specified in Section 2(4) of this administrative regulation.

(6) "Community spouse" means the spouse of a resident who is not herself or himself a resident of a state veterans' nursing home.

(7) "Department" means the Kentucky Department of Veterans' Affairs.

(8) "Dependent" means an individual less than eighteen (18) years of age who is in the resident's care.

(9) "Exclusions" means an amount deducted from a resident and spouse's gross monthly income and total assets to determine the ability to pay for services rendered by a nursing home.

(10) "Gross monthly income" means the amount of income received by the resident and spouse on a monthly basis plus those amounts originally withheld from wages and earnings.

(11) "Income" means funds received by the resident and spouse and shall include the following:

(a) VA, U.S. Civil Service, U.S. Railroad, Military, Social Security, and any other form of compensation and pension;
(b) Wages from all employers;
(c) Interest and dividends;
(d) Workers compensation; and
(e) Rental or other business income.

(12) "Nursing home" means a state veterans' nursing home operated by the Kentucky Department of Veterans' Affairs.

(13) "Resident" means a veteran admitted to a state veterans' nursing home.

(14) "Spouse" means the wife or husband of a resident who is not divorced or legally separated from the veteran.

(15) "Withholdings" means those dollar amounts originally deducted from monthly income, such as:

(a) Deductions for income taxes;
(b) Deductions for health and life insurance premiums; and
(c) Deductions for retirement plans.

Section 2. Determination of the Ability to Pay for Services Rendered at State Veterans' Nursing Homes. (1) The nursing home shall compute the ability to pay for each resident who is admitted to the facility for care.
(2) The amount a resident is required to pay for services shall be the lesser of:
(a) The maximum charge specified in 17 KAR 3:020; or
(b) The amount the resident is deemed able to pay in accordance with this administrative regulation.
(3) The nursing home shall determine an ability to pay amount for each resident based on the following factors:
(a) Available assets; and
(b) Available monthly income.
(4) The following shall be authorized exclusions from gross monthly income:
(a) Medicare B insurance premium (resident only);
(b) Health insurance premium (resident only), not to exceed $150 per month;
(c) A resident's personal needs allowance of $150 per month;
(d) A maintenance allowance for a community spouse of $1,500 per month;
(e) A maintenance allowance of $400 per month for each dependent;
(f) Court-ordered support payments to an ex-spouse, not to exceed $400 per month; or
(g) Court ordered support payments for a child less than eighteen (18) years of age, not to exceed $400 per child per month.
(5) The following shall be authorized exclusions from assets:
(a) Primary residence (including any contiguous land);
(b) A resident burial exclusion consisting of cash, life insurance policy, or prepaid burial plan with a combined value of $10,000 or less;
(c) A spousal exclusion consisting of an allocation of assets totaling $100,000 (or a lesser amount if sufficient assets are not available) on the date the resident is admitted;
(d) All household equipment and personal effects owned by the resident and spouse;
(e) One (1) automobile; and
(f) Any outstanding debts on the day of admission to the nursing home.
(6) If it is determined that a resident disposed of a nonexcluded asset by gift, or for an amount less than fair market value, during the two (2) year period preceding the date of admission, the monthly charge for room and care shall be computed as if the resident retained ownership of the asset as of the date of admission.
(7) The monthly spousal allowance and dependent's allowance shall be utilized by the resident to help meet the financial needs of his or her spouse or dependent. If the facility becomes aware that these allowances are not being utilized for their intended purpose, the resident's monthly charge for room and care shall be recalculated as if the resident were unmarried and without dependents.
(8) If a married couple is admitted to a nursing home, the monthly charge shall be computed as if each resident were unmarried and without dependents. All assets and debts of the residents shall be allocated at a rate of fifty (50) percent to each individual. All income earned by the couple shall be considered to be earned at a rate of fifty (50) percent to each. Only one (1) primary residence and one (1) automobile shall be excluded for purposes of computing available assets for the couple.

Section 3. Calculation of the Amount Resident is Able to Pay. (1) The nursing home shall calculate the ability to pay amount utilizing the "Ability to Pay Worksheet". The form shall be explained to the resident or person responsible for the resident and signed by all parties. A copy of this form shall be provided to the resident or person responsible for the resident.

(2) The amount of available assets shall be determined as follows:
(a) Calculate the total amount of assets owned by the resident and spouse;
(b) Apply the exclusions identified in Section 2(5) of this administrative regulation; and
(c) The remaining assets shall equal the available assets.
(3) The amount of available monthly income shall be determined as follows:
(a) Determine the amount of total monthly income for the resident and spouse;
(b) Identify all withholdings and add that total to total monthly income to determine gross monthly income;
(c) Apply the exclusions identified in Section 2(4) of this administrative regulation to the gross monthly income total; and
(d) The remaining income shall equal the available monthly income.
(4) The resident's monthly charge for room and care shall be computed as follows:
(a) Add the available assets to the available monthly income to determine the ability to pay amount:
(b) If the ability to pay amount is between $0 and the facility's maximum charge, the resident's monthly charge shall equal the ability to pay amount; and
(c) If the ability to pay amount is equal to or greater than the facility's maximum charge, the resident's monthly charge shall equal the facility's maximum charge.
(5) After the resident's ability to pay is determined, a "Patient or Responsible Party Financial Agreement" form shall be completed. The form shall be explained to the resident and signed by all parties. If the resident or person responsible for the resident refuses to sign, this refusal shall be noted on the form including the date the form was discussed. Refusal to sign the form shall result in the resident paying the maximum charge for room and care.

Section 4. Revisions to Ability to Pay Amounts. (1) Nursing home staff shall update a resident's ability to pay amount to incorporate changes that take place subsequent to the initial determination. These changes may include:
(a) Income revisions;
(b) Asset revisions including exhaustion of available assets;
(c) Changes in allowed exclusions; or
(d) Identification of previously undisclosed income or assets.
(2) Upon a change in the ability to pay information, a revised "Ability to Pay Worksheet" shall be prepared along with a revised "Patient or Responsible Party Financial Agreement" form. The revised forms shall be presented to the resident in the same manner as the original forms.

Section 5. Failure to Provide Financial Information or to Assign Benefits. (1) Failure of the resident to disclose financial information required to compute his or her ability to pay shall result in the resident paying the maximum charge for room and care.
(2) If the resident or person responsible for the resident fails to sign the assignment provision contained in the "Patient or Responsible Party Financial Agreement" form, the maximum charge for room and care shall be assessed.

Section 6. Payment Hardship and Appeal Procedures. (1) Payment hardships.
(a) If the resident or person responsible for the resident believes that the ability to pay amount will result in a financial hardship, the resident or responsible person may request to make installment payments.
(b) This request shall be made in writing to the nursing home's administrator and shall include documentation to support the claimed hardship.
(c) The administrator shall review the financial hardship request and render a payment plan decision within fifteen (15) days from the receipt of the hardship request.
(2) Appeals.
(a) If the resident or person responsible for the resident is aggrieved by the facility charges or a payment plan determined in accordance with this administrative regulation, the resident or person responsible for the resident

may appeal the determination to the Executive Director, Office of Kentucky Veterans' Centers, 1111 Louisville Road, Frankfort, Kentucky 40621, within thirty (30) days of the ability to pay or payment plan being calculated.

(b) The executive director shall review the appeal and issue a determination within fifteen (15) days of receipt.

(c) If the resident or person responsible for the resident is dissatisfied with the informal resolution, the resident or person responsible for the resident may file an appeal within thirty (30) days of the executive director's response to the Commissioner, Kentucky Department of Veterans Affairs, 1111 Louisville Road, Frankfort, Kentucky 40621. If the commissioner is unable to resolve the appeal request informally, he shall arrange for an administrative hearing in accordance with KRS Chapter 13B.

(d) The appeal request shall fully explain the resident's or responsible person's position and include all necessary supporting documentation.

Section 7. Incorporation by Reference. (1) The following material is incorporated by reference:

(a) OKVC Form #2, "Ability to Pay Worksheet", (October 10, 2006); and

(b) OKVC Form #3, "Patient or Responsible Party Financial Agreement", (October 12, 2006).

(2) This material may be inspected, copied, or obtained, subject to applicable copyright law, at the Department of Veterans Affairs, 1111B Louisville Road, Frankfort, Kentucky 40601, Monday through Friday, 8 a.m. to 4:30 p.m. (33 Ky.R. 1464; Am. 1786; eff. 2-2-2007.)

17 KAR 3:020. Maximum charge for room and care at state veterans' nursing homes.

17 KAR 3:020. Maximum charge for room and care at state veterans' nursing homes.

RELATES TO: KRS 40.320, 40.325
STATUTORY AUTHORITY: KRS 40.325(2)
NECESSITY, FUNCTION, AND CONFORMITY: KRS 40.320 identifies the Commonwealth's duty to provide for the well-being of elderly and disabled veterans within state veterans' nursing homes. KRS 40.325(2) authorizes the Department of Veterans' Affairs to promulgate any administrative regulations necessary to operate the homes in compliance with applicable state and federal statutes and regulations. This administrative regulation establishes the maximum monthly resident charge for room and care at state veterans' nursing homes.

Section 1. Definitions. (1) "Daily cost of care" means the total annual expenditures on nursing home operations divided by the total number of resident care days provided by the three (3) nursing homes during the course of the fiscal year.
(2) "Department" means the Kentucky Department of Veterans' Affairs.
(3) "Nursing home" means a state veterans' nursing home operated by the Kentucky Department of Veterans' Affairs.
(4) "Resident" means a veteran admitted to a state veterans' nursing home.

Section 2. Maximum Monthly Resident Charge. (1) The maximum charge for room and care services at a state veterans' nursing home shall be $3,500 per month, which shall include medical and nonmedical services provided by the nursing home.
(2) Medical services obtained from sources other than the nursing home may result in a charge from the source of care to the resident. These medical services may include:
(a) X-ray;
(b) Dental;
(c) Optometry;
(d) Hospitalization;
(e) Ambulance service;
(f) Hearing aids;
(g) Podiatry;
(h) Specialized medications not on the formulary; and
(i) Specialty care and equipment.
(3) The maximum monthly charge shall be revised periodically based on changes that occur which affect the nursing homes' expenditures or sources of income. These changes may include:
(a) Increases in the daily cost of care prompted by inflation in the cost of goods, services, and labor utilized to provide nursing care;
(b) Availability of general funds appropriated to the department by the legislature for operation of the three (3) state veterans' nursing homes; or
(c) Changes in the per diem allocated by the U.S. Department of Veterans' Affairs.
(4) If changes are made to the maximum monthly charge, each affected resident shall be notified in writing at least thirty (30) days prior to the change taking effect. The maximum amount shall not be changed without an amendment to this administrative regulation made in accordance with KRS Chapter 13A. (33 Ky.R. 1466; Am. 1787; eff. 2-2-2007; 35 Ky.R. 11; 611; eff. 12-4-2008.)

Department of Veterans Affairs

INSTRUCTIONS FOR COMPLETING APPLICATION FOR HEALTH BENEFITS

Step 1: Before You Start . . .

What is VA Form 10-10EZ used for?

- To apply for enrollment in the VA health care system, or for nursing home, domiciliary or dental benefits.

Where can I get help filling out the form?

- Contact a National or State Veterans Service Organization.
- Ask VA to help you fill out the form by calling or visiting a VA health care facility. Before you call or go to the VA health care facility, gather the necessary materials identified in Step 2 of the instructions and complete as much of the form as you can.

How can I contact VA if I have questions?

- Look in your telephone book blue pages under "United States Government, Veterans" to locate your local VA health care facility.
- Call VA's Health Benefits Service Center toll-free at 1-877-222-VETS (8387).
- Access our website at http://www.va.gov and select "Contact the VA."
- If you desire a health care appointment, contact the Enrollment Coordinator at your local VA health care facility for assistance in scheduling an appointment.

Definitions of terms used on this form

- SERVICE-CONNECTED (SC): A veteran with a VA determination that an illness or injury was incurred or aggravated in the line of duty, in the active military, naval or air service.
- COMPENSABLE: A determination by VA that a service-connected disability is severe enough to warrant monetary compensation.
- NONCOMPENSABLE: A determination by VA that a service-connected disability is not severe enough to warrant monetary compensation.
- NONSERVICE-CONNECTED (NSC): A veteran who does not have a VA determined service-related condition.

Which sections of VA Form 10-10EZ should you complete?

Look at the table below to find out which sections of VA Form 10-10EZ you should complete. The shaded sections should be completed only if you answer "Yes" to Section VI agreeing to provide income and asset information to establish eligibility for care. You may agree to copayments without providing this detailed financial information.

If you are...	Complete the sections marked with an X						
	I-IV	VI	VII	VIII	IX	X	XII
Service-connected 50% to 100%. *Answer YES in Section VI and complete Sections VII-IX to have your financial eligibility for waiver of travel deductions assessed.*	X	X	X	X	X		X
Service-connected 30-40%. *Answer YES in Section VI and complete Sections VII-IX to have your financial eligibility for cost-free medications for treatment of your nonservice-connected conditions and waiver of travel deductibles assessed.*	X	X	X	X	X		X
Service-connected 0% (compensable) or service-connected 10-20%. *Answer YES in Section VI and complete Sections VII-IX to have your financial eligibility for cost-free medications and beneficiary travel for treatment of your nonservice-connected conditions assessed.*	X	X	X	X	X		X
A Former POW. *Answer YES in Section VI and complete Sections VII-IX to have your financial eligibility for beneficiary travel assessed. Also, complete Section X if applying for long-term care.*	X	X	X	X	X		X
A veteran discharged from the military due to a disability incurred or aggravated in service or Purple Heart Medal recipient veteran. *Answer YES in Section VI and complete Sections VII-IX to have your financial eligibility for cost-free medications and beneficiary travel assessed. Also, complete Section X if applying for long-term care.*	X	X	X	X	X		X
Receiving nonservice-connected VA Pension, Aid and Attendance or Housebound benefits. *Answer YES in Section VI and complete Sections VII-X to have your financial eligibility for long-term care assessed. Unmarried VA Pensioners are excluded from this requirement.*	X	X	X	X	X	X	X
A recent combat veteran (e.g., OEF/OIF) with discharge from military within past 5 years or discharge from the military more than 5 years ago and applying for enrollment by Jan. 27, 2011. ***You are eligible for enrollment without providing your financial information.*** *If you answer YES in Section VI and complete Sections VII-X you will have your priority for enrollment and financial eligibility for cost-free medical care, medications, long-term care and beneficiary travel for treatment of your nonservice-connected conditions assessed.*	X	X	X	X	X	X	X
Service-connected 0% (noncompensable) or nonservice-connected with no special eligibilities listed above. *Answer YES in Section VI and complete Sections VII-X to have your priority for enrollment and financial eligibility for cost-free medical care, medications, long-term care and beneficiary travel for treatment of your nonservice-connected conditions assessed.*	X	X	X	X	X	X	X

Step 2: Completing your application ...

Review the table in Step 1 to find out what sections you should complete. Answer all questions in those sections. If you need more space to answer a question, attach a sheet of paper to the form containing your name and Social Security Number. For each question that you need more room, write "Continuation of Item" and write the section and question number.

Section II - Insurance Information. Include information for all health insurance policies that cover you. If you have more than one health insurer, provide this information on a separate sheet of paper and attach to the application. If you have access to a copier, attach a copy of your insurance cards, Medicare card and/or Medicaid card (Medicaid is a federal/state health insurance program for certain low-income people). Bring these cards with you to each health care appointment.

Section IV - Military Service Information.

If you are not currently receiving benefits from VA, you should attach a copy of your discharge or separation papers from the military (such as DD 214 or, for WWII veterans, a "WD" Form), with your signed application to expedite processing of your application.

If you indicate that you received a Purple Heart Medal, we will check our records for confirmation of your status. If we are unable to confirm your status as a Purple Heart Medal recipient, we will ask you to provide VA a copy of your DD-214 or other military service records or orders indicating you were awarded the medal. To reduce processing time, you may submit a copy of this documentation with your signed application.

Section VI - Financial Disclosure.

The financial assessment is used to determine whether certain veterans qualify for cost-free health care services for their NSC conditions and to assign their priority for enrollment. You should review the table in Step 1 to see if your eligibility for health care benefits requires or may be based on a financial assessment. Veterans are not required to disclose their financial information; however, VA is not currently enrolling new applicants who decline to provide their financial information unless they have a special eligibility factor. **Recent combat veterans (e.g., OEF/OIF) who were discharged within the past 5 years or discharged from the military more than 5 years ago and applying for enrollment by Jan. 27, 2011 are eligible for enrollment without disclosing their financial information** but like other veterans may provide it to establish their eligibility for travel reimbursement, cost-free medication and/or medical care for services unrelated to military experience and consideration for waiver of travel deductibles. If a financial assessment is not used to determine your priority for enrollment you may choose not to disclose your information and agree to make copayments for treatment of your NSC conditions. If a financial assessment is used to determine your eligibility for travel assistance or waiver, and you do not disclose your financial information, you will not be eligible for these benefits. **If you are such a veteran by signing this application you are agreeing to pay the applicable VA copayments as required by law.**

Section VII - Dependent Information. Use a separate sheet of paper for additional dependent children.

- You may count your spouse as your dependent even if you did not live together, as long as you contributed $600 or more in support last calendar year.
- You may count your biological children, adopted children, and stepchildren as dependents. But these children must be unmarried and under the age of 18, or be at least 18 but under 23 and attending high school, college or vocational school on a full or part-time basis, or have become permanently unable to support themselves before reaching the age of 18.
- Count child support contributions even if not paid in regular set amounts. Contributions can include tuition payments or payments of medical bills.

Section VIII - Previous Calendar Year Gross Annual Income of Veteran, Spouse and Dependent Children.

Use a separate sheet of paper for additional dependent children.

- Report: gross annual income from employment, except for income from your farm, ranch, property or business, including information about your wages, bonuses, tips, severance pay and other accrued benefits and your child's income information if it could have been used to pay your household expenses
- Report: net income from your farm, ranch, property or business.
- Report: other income amounts, including retirement and pension income, Social Security Retirement and Social Security Disability income, compensation benefits such as VA disability, unemployment, Workers and black lung, cash gifts, interest and dividends, including tax exempt earnings and distributions from Individual Retirement Accounts (IRAs) or annuities
- Do Not Report: Welfare, Supplemental Security Income (SSI) and need-based payments from a government agency, profit from the occasional sale of property, income tax refunds, reinvested interest on Individual Retirement Accounts (IRAs), scholarships and grants for school attendance, disaster relief payment or proceeds of casualty insurance, loans, Agent Orange and Alaska Native Claim Settlement Acts Income and payments to foster parents.

Section IX - Previous Calendar Year Deductible Expenses. Report nonreimbursed medical expenses paid by you or your spouse. Include expenses for medical and dental care, drugs, eyeglasses, Medicare, medical insurance premiums and other health care expenses paid by you for dependents and persons for whom you have a legal or moral obligation to support. Do not list expenses if you expect to receive reimbursement from insurance or other sources.

Section X - Previous Calendar Year Net Worth. Use a separate sheet of paper for additional dependent children.

Your net worth is the market value of all the interest and rights you have in any kind of property. However net worth does not include your single-family residence and a reasonable lot area surrounding it. It also does not include the personal things you use every day like your vehicle, clothing and furniture.

Step 3: Submitting your application ...What do I do when I have finished my application?

- Read Section V, Paperwork Reduction and Privacy Act Information , Section XI Consent to Copayments and Section XII, Assignment of Benefits.
- Make sure you sign and date VA Form 10-10EZ in Section XII. You or an individual to whom you have delegated your Power of Attorney must sign and date the form. If you sign with an "X", then you must have 2 people you know witness you as you sign. They must then sign the form and print their names. If the form is not signed and dated appropriately, VA will return it for you to complete. This will result in a delay in processing your application.
- Attach any continuation sheets and necessary material to your application.

Where do I send my application? Mail the original application with a copy of your supporting materials to your local VA care facility. You can find the address in your local telephone book, by calling toll-free 1-877-222-VETS (8387), or on the Internet at http://www.va.gov.

OMB Approved No. 2900-0091
Estimated Burden Avg. 45 min.

Department of Veterans Affairs

APPLICATION FOR HEALTH BENEFITS

SECTION I - GENERAL INFORMATION

Federal law provides criminal penalties, including a fine and/or imprisonment for up to 5 years, for concealing a material fact or making a materially false statement. (See 18 U.S.C. 1001)

1. VETERAN'S NAME *(Last, First, Middle Name)*	2. OTHER NAMES USED	3. MOTHER'S MAIDEN NAME	4. GENDER ☐ MALE ☐ FEMALE

5. ARE YOU SPANISH, HISPANIC, OR LATINO? ☐ YES ☐ NO	6. WHAT IS YOUR RACE? *(You may check more than one.) (Information is required for statistical purposes only.)* ☐ AMERICAN INDIAN OR ALASKA NATIVE ☐ BLACK OR AFRICAN AMERICAN ☐ ASIAN ☐ WHITE ☐ NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER

7. SOCIAL SECURITY NUMBER	9. DATE OF BIRTH *(mm/dd/yyyy)*	10. RELIGION
8. CLAIM NUMBER	9A. PLACE OF BIRTH *(City and State)*	

11. PERMANENT ADDRESS *(Street)*	11A. CITY	11B. STATE	11C. ZIP CODE *(9 digits)*
11D. COUNTY	11E. HOME TELEPHONE NUMBER *(Include area code)*	11F. E-MAIL ADDRESS	
11G. CELLULAR TELEPHONE NUMBER *(Include area code)*	11H. PAGER NUMBER *(Include area code)*		

12. TYPE OF BENEFIT(S) APPLIED FOR *(You may check more than one)*
☐ HEALTH SERVICES ☐ NURSING HOME ☐ DOMICILIARY ☐ DENTAL

13. IF APPLYING FOR HEALTH SERVICES OR ENROLLMENT, WHICH VA MEDICAL CENTER OR OUTPATIENT CLINIC DO YOU PREFER?

14. DO YOU WANT AN APPOINTMENT WITH A VA DOCTOR OR PROVIDER AS SOON AS ONE BECOMES AVAILABLE? ☐ YES ☐ NO I am only enrolling in case I need care in the future.	15. HAVE YOU BEEN SEEN AT A VA HEALTH CARE FACILITY? ☐ YES, **LOCATION:** ☐ NO

16. CURRENT MARITAL STATUS *(Check one)*
☐ MARRIED ☐ NEVER MARRIED ☐ SEPARATED ☐ WIDOWED ☐ DIVORCED ☐ UNKNOWN

17. NAME, ADDRESS AND RELATIONSHIP OF NEXT OF KIN	17A. NEXT OF KIN'S HOME TELEPHONE NUMBER *(Include area code)*
	17B. NEXT OF KIN'S WORK TELEPHONE NUMBER *(Include area code)*
18. NAME, ADDRESS AND RELATIONSHIP OF EMERGENCY CONTACT	18A. EMERGENCY CONTACT'S HOME TELEPHONE NUMBER *(Include area code)*
	18B. EMERGENCY CONTACT'S WORK TELEPHONE NUMBER *(Include area code)*

19. INDIVIDUAL TO RECEIVE POSSESSION OF YOUR PERSONAL PROPERTY LEFT ON PREMISES UNDER VA CONTROL AFTER YOUR DEPARTURE OR AT THE TIME OF DEATH. NOTE: THIS DOES NOT CONSTITUTE A WILL OR TRANSFER OF TITLE *(Check one)*
☐ EMERGENCY CONTACT ☐ NEXT OF KIN

APPLICATION FOR HEALTH BENEFITS, Continued	VETERAN'S NAME *(Last, First, Middle)*	SOCIAL SECURITY NUMBER

SECTION II - INSURANCE INFORMATION ***(Use a separate sheet for additional information)***

1. ARE YOU COVERED BY HEALTH INSURANCE? *(Including coverage through a spouse or another person)* ☐ YES ☐ NO			2. HEALTH INSURANCE COMPANY NAME, ADDRESS AND TELEPHONE NUMBER
3. NAME OF POLICY HOLDER			
4. POLICY NUMBER	5. GROUP CODE		
	YES	**NO**	
6. ARE YOU ELIGIBLE FOR MEDICAID?	☐	☐	
7. ARE YOU ENROLLED IN MEDICARE HOSPITAL INSURANCE PART A?	☐	☐	7A. EFFECTIVE DATE *(mm/dd/yyyy)*
8. ARE YOU ENROLLED IN MEDICARE HOSPITAL INSURANCE PART B?	☐	☐	8A. EFFECTIVE DATE *(mm/dd/yyyy)*
9. NAME EXACTLY AS IT APPEARS ON YOUR MEDICARE CARD			10. MEDICARE CLAIM NUMBER
11. IS NEED FOR CARE DUE TO ON THE JOB INJURY? *(Check one)* ☐ YES ☐ NO			12. IS NEED FOR CARE DUE TO ACCIDENT? *(Check One)* ☐ YES ☐ NO

SECTION III - EMPLOYMENT INFORMATION

1. VETERAN'S EMPLOYMENT STATUS *(Check one)* ☐ FULL TIME ☐ NOT EMPLOYED ☐ PART TIME ☐ RETIRED ***If employed or retired, complete item 1A*** *Date of retirement (mm/dd/yyyy)*	1A. COMPANY NAME, ADDRESS AND TELEPHONE NUMBER
2. SPOUSE'S EMPLOYMENT STATUS *(Check one)* ☐ FULL TIME ☐ NOT EMPLOYED ☐ PART TIME ☐ RETIRED ***If employed or retired, complete item 2A*** *Date of retirement (mm/dd/yyyy)*	2A. COMPANY NAME, ADDRESS AND TELEPHONE NUMBER

SECTION IV - MILITARY SERVICE INFORMATION

1. LAST BRANCH OF SERVICE	1A. LAST ENTRY DATE	1B. LAST DISCHARGE DATE	1C. DISCHARGE TYPE	1D. MILITARY SERVICE NUMBER

2. CHECK YES OR NO	**YES**	**NO**		**YES**	**NO**
A. ARE YOU A PURPLE HEART AWARD RECIPIENT?	☐	☐	E1. ARE YOU RECEIVING DISABILITY RETIREMENT PAY INSTEAD OF VA COMPENSATION?	☐	☐
B. ARE YOU A FORMER PRISONER OF WAR?	☐	☐	F. DO YOU NEED CARE OF CONDITIONS POTENTIALLY RELATED TO SERVICE IN SW ASIA DURING THE GULF WAR?	☐	☐
C. DO YOU HAVE A VA SERVICE-CONNECTED RATING?	☐	☐	G. WERE YOU EXPOSED TO AGENT ORANGE WHILE SERVING IN VIETNAM?	☐	☐
C1. IF YES, WHAT IS YOUR RATED PERCENTAGE? **%**			H. WERE YOU EXPOSED TO RADIATION WHILE IN THE MILITARY?	☐	☐
D. DID YOU SERVE IN COMBAT AFTER 11/11/1998?	☐	☐	I. DID YOU RECEIVE NOSE AND THROAT RADIUM TREATMENTS WHILE IN THE MILITARY?	☐	☐
E. WAS YOUR DISCHARGE FROM MILITARY FOR A DISABILITY INCURRED OR AGGRAVATED IN THE LINE OF DUTY?	☐	☐	J. DO YOU HAVE A SPINAL CORD INJURY?	☐	☐

SECTION V - PAPERWORK REDUCTION ACT AND PRIVACY ACT INFORMATION

The Paperwork Reduction Act of 1995 requires us to notify you that this information collection is in accordance with the clearance requirements of Section 3507 of the Paperwork Reduction Act of 1995. We may not conduct or sponsor, and you are not required to respond to, a collection of information unless it displays a valid OMB number. We anticipate that the time expended by all individuals who must complete this form will average 45 minutes. This includes the time it will take to read instructions, gather the necessary facts and fill out the form.

Privacy Act Information: VA is asking you to provide the information on this form under 38 U.S.C. Sections 1705, 1710, 1712, and 1722 in order for VA to determine your eligibility for medical benefits. Information you supply may be verified through a computer-matching program. VA may disclose the information that you put on the form as permitted by law. VA may make a "routine use" disclosure of the information as outlined in the Privacy Act systems of records notices and in accordance with the VHA Notice of Privacy Practices. Providing the requested information is voluntary, but if any or all of the requested information is not provided, it may delay or result in denial of your request for health care benefits. Failure to furnish the information will not have any effect on any other benefits to which you may be entitled. If you provide VA your Social Security Number, VA will use it to administer your VA benefits. VA may also use this information to identify veterans and persons claiming or receiving VA benefits and their records, and for other purposes authorized or required by law.

APPLICATION FOR HEALTH BENEFITS, Continued

VETERAN'S NAME *(Last, First, Middle)*

SOCIAL SECURITY NUMBER

SECTION VI - FINANCIAL DISCLOSURE

Disclosure allows VA to accurately determine whether certain veterans will be charged copayments for care and medications, their eligibility for other services and enrollment priority. Veterans are not required to disclose their financial information; however, VA is not currently enrolling new applicants who decline to provide their financial information unless they have a special eligibility factor. **Recent combat veterans (e.g., OEF/OIF) who were discharged within the past 5 years or were discharged more than 5 years ago and applying for enrollment by Jan. 27, 2011 are eligible for enrollment without disclosing their financial information** but like other veterans may provide it to establish their eligibility for travel reimbursement, cost-free medication and/or medical care for services unrelated to military experience.

☐ **No, I do not wish to provide financial information in Sections VII through X.** I understand that VA is not enrolling new applicants who do not provide this information and who do not have a special eligibility factor (e.g., recently discharged combat veteran, compensable service connection, receipt of VA pension or Medicaid benefits.) If I am enrolled, I agree to pay applicable VA copayments. *Sign and date the form in Section XII.*

☐ **Yes, I will provide my household financial information for last calendar year.** Complete applicable sections VII through X . S*ign and date the form in Section XII.*

SECTION VII - DEPENDENT INFORMATION *(Use a separate sheet for additional dependents)*

1. SPOUSE'S NAME *(Last, First, Middle Name)*	2. CHILD'S NAME *(Last, First, Middle Name)*
1A. SPOUSE'S MAIDEN NAME	2A. CHILD'S RELATIONSHIP TO YOU *(Check one)* ☐ *Son* ☐ *Daughter* ☐ *Stepson* ☐ *Stepdaughter*
1B. SPOUSE'S SOCIAL SECURITY NUMBER	2B. CHILD'S SOCIAL SECURITY NUMBER / 2C. DATE CHILD BECAME YOUR DEPENDENT *(mm/dd/yyyy)*
1C. SPOUSE'S DATE OF BIRTH *(mm/dd/yyyy)* / 1D. DATE OF MARRIAGE *(mm/dd/yyyy)*	2D. CHILD'S DATE OF BIRTH *(mm/dd/yyyy)*
1E. SPOUSE'S ADDRESS AND TELEPHONE NUMBER *(Street, City, State, ZIP)*	2E. WAS CHILD PERMANENTLY AND TOTALLY DISABLED BEFORE THE AGE OF 18? ☐ YES ☐ NO 2F. IF CHILD IS BETWEEN 18 AND 23 YEARS OF AGE, DID CHILD ATTEND SCHOOL LAST CALENDAR YEAR? ☐ YES ☐ NO
3. IF YOUR SPOUSE OR DEPENDENT CHILD DID NOT LIVE WITH YOU LAST YEAR ENTER THE AMOUNT YOU CONTRIBUTED TO THEIR SUPPORT. SPOUSE $ CHILD $	2G. EXPENSES PAID BY YOUR DEPENDENT CHILD FOR COLLEGE, VOCATIONAL REHABILITATION OR TRAINING *(e.g., tuition, books, materials)* $

SECTION VIII - PREVIOUS CALENDAR YEAR GROSS ANNUAL INCOME OF VETERAN, SPOUSE AND DEPENDENT CHILDREN *(Use a separate sheet for additional dependents)*

	VETERAN	SPOUSE	CHILD 1
1. GROSS ANNUAL INCOME FROM EMPLOYMENT *(wages, bonuses, tips, etc.)* EXCLUDING INCOME FROM YOUR FARM, RANCH, PROPERTY OR BUSINESS	$	$	$
2. NET INCOME FROM YOUR FARM, RANCH, PROPERTY OR BUSINESS	$	$	$
3. LIST OTHER INCOME AMOUNTS *(eg., Social Security, compensation, pension interest, dividends)*. EXCLUDING WELFARE.	$	$	$

SECTION IX - PREVIOUS CALENDAR YEAR DEDUCTIBLE EXPENSES

1. TOTAL NON-REIMBURSED MEDICAL EXPENSES PAID BY YOU OR YOUR SPOUSE *(e.g., payments for doctors, dentists, medications, Medicare, health insurance, hospital and nursing home) VA will calculate a deductible and the net medical expenses you may claim.*	$
2. AMOUNT YOU PAID LAST CALENDAR YEAR FOR FUNERAL AND BURIAL EXPENSES FOR YOUR DECEASED SPOUSE OR DEPENDENT CHILD *(Also enter spouse or child's information in Section VII.)*	$
3. AMOUNT YOU PAID LAST CALENDAR YEAR FOR YOUR COLLEGE OR VOCATIONAL EDUCATIONAL EXPENSES *(e.g., tuition, books, fees, materials) DO NOT LIST YOUR DEPENDENTS' EDUCATIONAL EXPENSES.*	$

SECTION X - PREVIOUS CALENDAR YEAR NET WORTH *(Use a separate sheet for additional dependents)*

	VETERAN	SPOUSE	CHILD 1
1. CASH, AMOUNT IN BANK ACCOUNTS *(e.g., checking and savings accounts, certificates of deposit, individual retirement accounts, stocks and bonds)*	$	$	$
2. MARKET VALUE OF LAND AND BUILDINGS MINUS MORTGAGES AND LIENS. *(e.g., second homes and non-income producing property. Do not count your primary home.)*	$	$	$
3. VALUE OF OTHER PROPERTY OR ASSETS *(e.g., art, rare coins, collectables)* MINUS THE AMOUNT YOU OWE ON THESE ITEMS. INCLUDE VALUE OF FARM, RANCH OR BUSINESS ASSETS. *Exclude household effects and family vehicles.*	$	$	$

SECTION XI - CONSENT TO COPAYMENTS

If you are a 0% SC veteran and do not receive VA monetary benefits or a NSC veteran (and you are not a Former POW, Purple Heart Recipient or VA pensioner) and your household income (or combined income and net worth) exceeds the established threshold, this application will be considered for enrollment, but only if you agree to pay VA copayments for treatment of your NSC conditions. **If you are such a veteran by signing this application you are agreeing to pay the applicable VA copayments as required by law.**

SECTION XII - ASSIGNMENT OF BENEFITS

I understand that pursuant to 38 U.S.C. Section 1729, VA is authorized to recover or collect from my health plan (HP) for the reasonable charges of nonservice-connected VA medical care or services furnished or provided to me. I hereby authorize payment directly to VA from any HP under which I am covered (including coverage provided under my spouse's HP) that is responsible for payment of the charges for my medical care, including benefits otherwise payable to me or my spouse.

ALL APPLICANTS MUST SIGN AND DATE THIS FORM. REFER TO INSTRUCTIONS WHICH DEFINE WHO CAN SIGN ON BEHALF OF THE VETERAN.

SIGNATURE OF APPLICANT	DATE

Send to THVC